



Scott K Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin

Department of Health Services

DIVISION OF PUBLIC HEALTH

1 WEST WILSON STREET
P O BOX 2659
MADISON WI 53701-2659

608-266-1251
FAX: 608-267-2832
TTY: 888-701-1253
dhfs.wisconsin.gov

VARIANCE PETITION APPLICATION

Please only *One* request addressing a *Single Concern* per form:

NOTE: The Variance Petitioner shall consult with the DHS Regional Coordinators and/or State Staff/Agent Local Health Department inspection officials in completing this form. DHS Regional Coordinators and/or State staff/Agent Local Health Department inspection officials shall approve the variance before sending the request to Central Office, FSRL.

1. Name of Legal Licensee of the Business (Sole Proprietor, Inc. LLC, LLP, etc.):

2. Affected Establishment Type: (Highlight or circle one)

Restaurant
Temporary Restaurant
Caterer
Mobile Restaurant
Special Organization Serving Meals (4-12
days in a 12 month period)
Pool
Whirlpool
Water Attraction
Water Slide

Hotel/Motel
Tourist Rooming House/cabin/cottage
Bed and Breakfast Establishment
Campground
Special Event Campground
Recreational/Educational Camp
Vending Machine Operation
Body Art Establishment
Other _____

3. **Establishment Name:**
4. **Establishment Address:**
(Include more address information than "Rural Route")
5. **Establishment ID Number:** n/a
6. **Provide the administrative code reference that applies to the request:**
7. **Subject/Issue (Explain the specific practice, provision, operation, condition, construction, installation or issue. Please be concise.):**
8. **State the date you wish to have this petition enforced:**
9. **Justification:** (Explain in detail why a variance is being requested. Clearly state why compliance with the code cannot be attained without a variance.) Explain the effect(s) of the modification/omission on public health or safety. State your proposed means and rationale of providing equivalent degree of protections. Include additional pages here if necessary :

The burden of proof for convincing information is the responsibility of the submitter's. It is the responsibility of the petitioner to consult the *DHS Regional Coordinators, State staff and/or Agent Local Health Department inspection officials in their jurisdictions to review and ensure that the inspection official state their position on the variance request and sign in the appropriate space before sending to FSRL Central Office. Failure to do so will result in an extended delay in the review process. Failure to provide required information is an automatic justification for this agency's denial of a petition. Additionally, the petitioner should be aware Central Office may take up to 30 days to review the variance request.

Please attach all pertinent and representative photographs, sketches, relevant and current documentation, test reports, research articles, expert opinions, previously approved variances, testing certifications, manufacturers' required standards conformance, testimonials/approvals from regulatory officials, etc. specific for your request. Must include the *official's name(s), titles, agency and relationship to the issue along with their phone number(s) and e-mails.. Make copies of all submittals. This information will not be returned and will be included in the state record.

*** Call FSRL at 608-266-2835 for a list of agent health departments/state regulatory officials.**

The information contained herein is accurate and truthfully representative of the conditions and circumstances relevant to this petition for variance. I understand that any approval from DHFS can be conditional and defined for a limited period of time as experimental or trial only. I understand the consequences of misrepresentation and penalties of perjury and State Statute chapter 254.85(5) (b) (2).

Date sent to DHFS: _____ Address request to: "VARIANCE PETITION: Attention: Section Chief FSRL, Rm 150, 1 W. Wilson St. Madison, WI 53701-2659":

Signature of Legal Representative
of Affected Business: _____

Printed Name: _____

PHONE NUMBER:

CELL NUMBER:

FAX NUMBER:

E-MAIL ADDRESS:

MAILING ADDRESS:

OFFICE USE ONLY**Establishment Name:****Receipt of State/Agent LPHD:**

Yes

No

Name:

Title:

Agency/Regional Office:

Date:

Approve

Deny

No Opinion

Comments:

Official's Signature:

Printed Name:

OFFICE USE ONLY**FSRL DECISION:**

DATE:

APPROVED

DENIED

REASON:

Signature of Section Chief:

Printed name:

Notification date sent: